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ABSTRACT

Described is Rhode Island's method of screening the preschool population for possible handicaps (Child Find). The system is seen to include casefinding (every child over 2.5 years not yet in school) using locally tailored public awareness campaigns, large scale screening (a quick survey of medical, sensory, motor, social, emotional, cognitive, language, and perceptual development), rescreening for those identified during screening, and either specific evaluation (one area of development) or in-depth assessment (two or more areas). (DB)

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IMPLEMENTING A COMPREHENSIVE EARLY IDENTIFICATION AND INTERVENTION SYSTEM - WITHOUT REINVENTING THE WHEEL

- RHODE ISLAND'S APPROACH TO SCREENING 39,000 CHILDREN

Judith S. Siegel and Ruth H. Schennum

The objective of this paper is to discuss the design and implementation of a systematic procedure for identifying and serving young handicapped children through a state coordinated effort - an approach, at this point in time, which appears somewhat unique to Rhode Island.

Before actually discussing the process, however, some background information seems pertinent. In recent years a considerable amount of both national and local attention has focused upon the issue of determining a practical method for identifying, locating, evaluating, and serving handicapped children. Impetus for such interest has come from a variety of sources, not the least of which has been federal legislation. The U.S. offices of Education, Child Development, and Social and Rehabilitative Services, to name just a few, have each issued mandates for large scale early identification and intervention programs. Most recently Public Law 94-142 has catapulted into the limelight and is having considerable impact upon the development and implementation of identification and intervention procedures for young handicapped children. State and local agencies have been scurrying about, hither and yon, searching for procedures to meet this mandate. Unfortunately, many such agencies are more interested in quickly adopting procedures that will protect them from legal entanglements, rather than adopting procedures that will insure high quality programs for young handicapped children.

In Rhode Island the need for action has been even more imminent. As a result of a 1975 out-of-court agreement to a class action suit brought against the State Board of Regents by parents of handicapped children, the Department of Education contracted with Ruth Schennum and Judy Siegel to design and implement a state-coordinated model for identifying and serving all preschool handicapped children by September, 1977 - a full year earlier than required by federal law. It was proposed that a model be developed that would draw upon already existing, validated practices and which could be adapted to the unique characteristics of Rhode Island's population, thereby implementing a sound, early recognition and intervention program without "reinventing the wheel."

It is interesting to note that legislation for services to Rhode Island's preschool handicapped children dates back to 1963. Total compliance with this legislation, however, has been another issue.

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Prior to the class action suit, few, if any, school districts sought to reach out and identify preschool children in its community who might be eligible for special education and/or related services. In most cases, services were provided to those handicapped children who were brought to the schools' attention by knowledgeable parents, physicians, or agencies and only after pressure had been brought to bear on high ranking administrators. Thus, for most handicapped children, services did not become available until they had entered elementary school and met with considerable failure.

When we set out in 1975 to tackle the problem of determining a practical method of identification, our first task was to collect and analyze current data regarding the numbers of preschool children identified and served. The results of this analysis were fascinating. Out of an estimated statewide population of 39,000 preschool children, we found that only 251 (a little more than ½ of 1%) were enrolled in special education programs and/or were in receipt of therapeutic practices (related services) being paid for by school systems.

In contrast, however, comparison of these figures with either national incidence figures for preschool children or incidence figures for 6 - 9 year olds in Rhode Island revealed dramatic differences. National incidence figures estimate that 12.07% of the preschool population are in need of special education and/or related services. In our own state 12.74% of the elementary school-age population had been identifed as handicapped and were receiving special education services and/or related services. There was no doubt that our traditional identification procedures, which consisted of referrals by parents, agencies, physicians, etc., were resulting in far too many false negatives (underreferrals) and could not be considered "practical" or "efficient." To reduce the number of false negatives and to determine a better method of identifying handicapped children, it was essential for us to modify our approaches - - a task now confronting almost every other state in the nation.

In line with our philosophy of not "reinventing the wheel," we took a look at the way in which other states were gearing up for their early identification and intervention efforts. Our search, unfortunately, was somewhat disappointing, for we found that although most states were attempting to decrease their incidence of false negatives by disseminating public awareness materials to the traditional referral agents (parents, physicians, agencies) they were still depending upon these sources to "pre-select" and subjectively decide the appropriateness of a referral. If a "pre-selected" referral approach was inefficient, would an open, "unselected" approach be a reasonable alternative? Would it make sense to objectively screen every child rather than depend upon subjective "pre-selection" by traditional referral sources? Might not a large scale screening program for all preschoolers be a solution to the high rate of false negatives? The notion of large scale screening certainly appeared promising; however, it, too, carried risks. Although screening every child would sharply reduce the incidence of false negatives, it also had the potential to substantially increase the probability of false positives (overreferrals) Secondly, the prospect of screening 39,000

children was overwhelming. Who would screen them? What would be screened? And, most importantly, how would they be followed up? The fields of medicine, psychology, and education are replete with instruments which purport to screen various disabling conditions. The market is glutted with such products. The consumer is, at best, confused. To suggest large scale screening to frantic school systems who, under the best of conditions, will purchase anything that comes in an attractively packaged kit would be to invite pandemonium, not to mention disaster. In addition, school systems have a penchant for wanting to develop their own "home-grown" instruments and procedures. With all the research that has already taken place, it seemed only logical to thoroughly review the fields of screening, assessment, and intervention as it pertained to the identification and treatment of handicapping conditions and to draw upon the existing information in the design of Rhode Island's program. Thus, utilizing existing, valid and reliable procedures and practices, we designed a progressive, funnelling recognition and intervention system, which substantially reduces the probability of false negatives and false positives, and developed a competency-based training program to accompany that system. The flow chart on the following page serves to diagram that system.

As can be seen from the chart, Casefinding is the first step in the process and is defined as locating (having the name, address, and telephone number) the parent or guardian of every child over the age of 2½ who is not yet in school so that they may be invited to participate in step 2 of the process, Large Scale Screening. Ideally at Casefinding, we aim to reach 100% of the population. When we first approached the task of Casefinding, we made the assumption, as most other people have, that the information contained in the local annual census was accurate and that since census takers were required to ask residents about the number of legally diagnosed handicapped children within their household, this information could be used as a basis for identifying eligible children. That was our first mistake. Upon closer inspection we found that local census-taking methods varied considerably between districts, thus making the data gathered highly suspect. Since the local census was not an adequate source for identification purposes, nor were the traditional referral agents (parents, agencies, physicians), we decided that the major thrust of Casefinding in Rhode Island would be to increase the public's awareness of normal growth and development, their knowledge of the services, and the means by which such services may be obtained. Unlike most other states that chose to "blitz" their regions with advertisements for handicapped children via the media, we analyzed the demographic and background characteristics of each section of our state and specifically tailored our outreach to meet the unique needs of each population. The characteristics which proved to be significant factors in determining the strategies used in the public awareness campaign were:

. Sociological concerns - average educational level, ethnic background, and language dominance of adults residing in that community

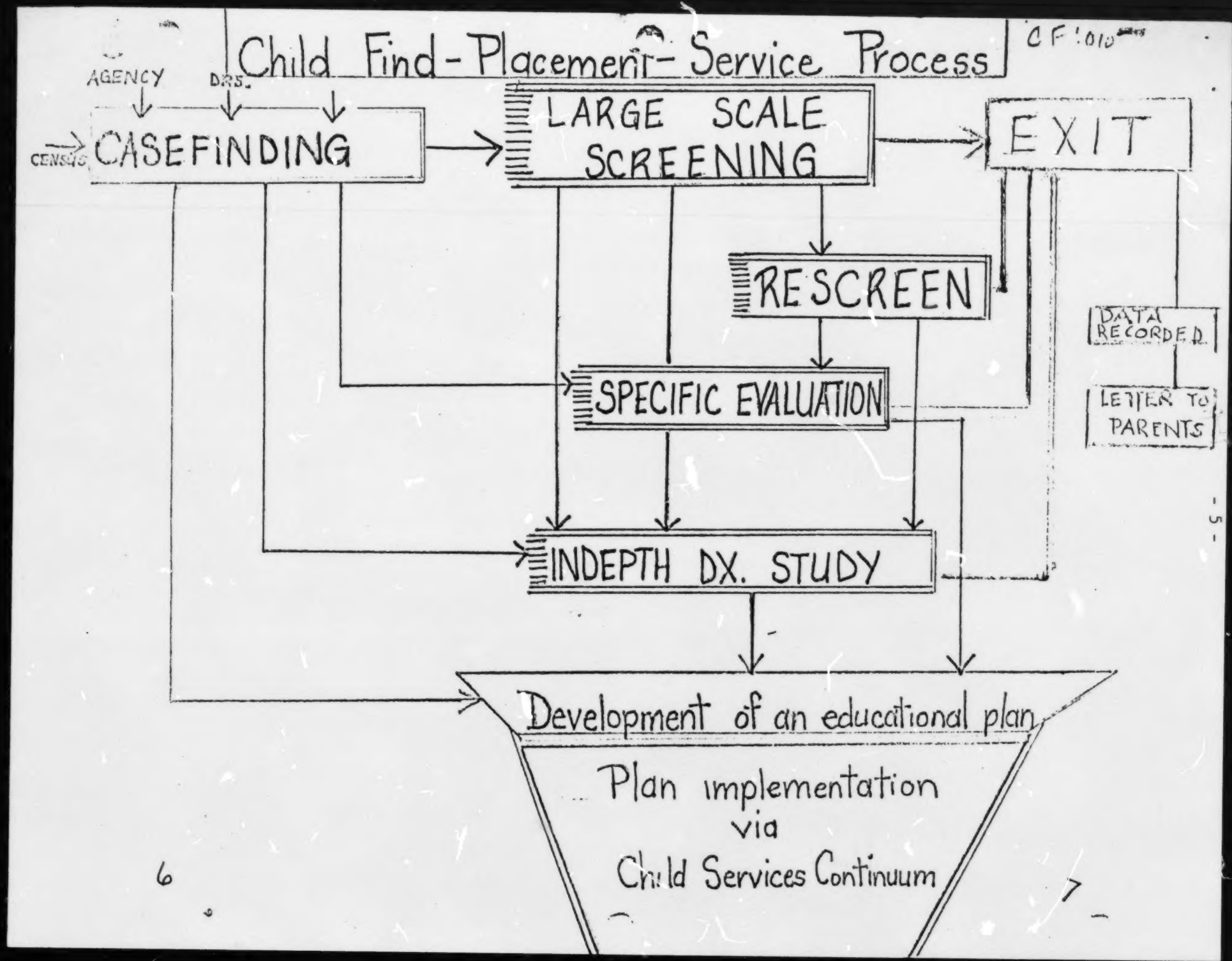
. Incidence of already identified handicapped preschool children
. Size and desnity of population
. Rural, urban, suburban characteristics

This model of public awareness and the materials designed to implement it were then disseminated to the 40 school districts, and personnel in those districts were provided with training. In this way the public awareness thrust for Rhode Island was carried out on a local rather than a more impersonal statewide level. Still, with all these modifications, our data revealed that there were significant differences among communities, and that these differences were related to the motivation of communities to actually identify their target population. One way of assessing the effectiveness of this outreach effort was to look at the number of children who actually participate in Large Scale Screening. This number ranged from 8% and 82% of the children in various communities with the state as a whole averaging 43%. Generally speaking, we found that the smaller, rural communities that used direct public awareness methods which involve considerable personal contact (i.e., phone calls, door-to-door canvass, etc.) as well as community mobilization for publicity (i.e., local volunteers, speakers bureaus, etc.) were more successful in their Casefinding efforts than large urban areas where public awareness approaches were usually more indirect (i.e., posters, flyers, brochures, etc.)

The second step in the process as indicated on the flow chart is Large Scale Screening, which is defined as the annual administration of brief, standardized instruments which have repeatedly demonstrated acceptable levels of reliability and validity and can be administered quickly and inexpensively by trained non-professionals to the total population of children over the ages of 2½ who are not yet in school. The purpose of this screening is to quickly survey the following areas, using instruments which lend themselves to cut-off scores:

. Medical conditions as they affect the learning process
. Physical/Sensory capacities
    Vision
    Hearing
. Motor skills
    Gross
    Fine
. Social, emotional, and adaptive behavior
. Cognitive skills
. Language skills
. Perceptual skills

Thus, screening is a first sorting to identify those children who do not require further assessment at this point in time from those


Child Find-Placement-Service Process
CF:010
AGENCY
DRS.
CENSUS
CASEFINDING
LARGE SCALE SCREENING
EXIT
RESCREEN
DATA RECORDED
LETTER TO PARENTS
SPECIFIC EVALUATION
INDEPTH DX. STUDY
Development of an educational plan
Plan implementation via Child Services Continuum

children for whom a "second look," Rescreening, is indicated. The total screening process takes about one hour and costs approximately $3 to $4.50 per child. Every aspect of the Large Scale Screening process has been carefully defined and is accompanied by a competency-based training program for non-professionals, which insures high levels of inter and intra-rater reliability. Since screening is merely a first sorting, and since the nature of the progressive, funneling identification process is designed to over-identify at this step, the use of highly paid professionals at Large Scale Screening is contraindicated. About 65% of the children who participate in Large Scale Screening exit from the system at this step.

However, for children who fail or whose performance is questionable in one or more areas of screening, a Rescreening is conducted. Because of the variability of the young child's functioning, it was felt that Rescreening should always be carried out by personnel different from those involved in the initial screening process, but should utilize the same instruments administered in the same areas which were in question at Large Scale Screening. The purpose of Rescreening is to clarify questions raised during the Large Scale Screening process in order to determine if the child should be further referred for a more in-depth and costly diagnostic evaluation. We have found that Rescreening usually involves a follow-up of approximately 35% of the screened population and since it is designed to differentiate between children who do not require further diagnostic assessment from children for whom a more in-depth diagnostic study is indicated, it decreases the probability of false positives. Approximately half of the children who do return for Rescreening exit with no need for follow-up. For the other half of the children questions are raised that must be answered through a thorough diagnostic assessment, and a Specific Evaluation or In-Depth Assessment is indicated.

Specific Evaluations refer to an intensive look in one area of development as opposed to In-Depth Assessment, which looks at two or more areas of the child's functioning through a team approach. Both are carried out by licensed/certified professionals in the areas failed or in question at Rescreening. For our purposes we have defined the criteria for eligibility as a child whose current level of functioning is 2 s.c. or greater below the mean in any one area assessed or 1.5 s.d. or greater below the mean in any two or more areas assessed. Specific and In-Depth Assessments are designed to answer the following questions:

1) Is this child eligible for special education and/or related services?

2) What should be the long-range goals of such services?

3) Where should these services be carried out?

If question 1 is answered in the affirmative, then the skeletal framework of an individual educational plan is designed with respect to the other two questions; i.e., long-range goals are established based on the child's present level of functioning and the setting

where those goals (services) can be carried out is determined according to the "least-restrictive, most-appropriate" alternative. Once these decisions have been made, the final step in the assessment process occurs; whereby, criterion-referenced instruments are administered to determine the essentials of the short-term objectives of the plan: What will be done, How will it be done, Who will do it, When it will be done, and How we will know it has been done.

So you can see that the total Child Find process from Case-finding through Screening and Rescreening, and the Specific and In-Depth Assessment gives us the opportunity to take a look at every pre-school child and to ferret out those children who are truly in need of special services.

Our system is certainly not perfect, but we feel at this point in time that we have drawn together and organized the best information and procedures our fields presently have to offer; and we've done it inexpensively, efficiently, and, most importantly, without "re-inventing the wheel."

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